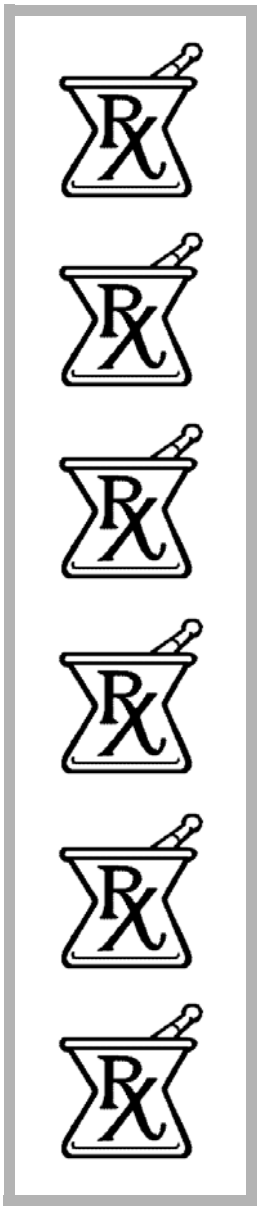

Prescription Drug Program

MONTANA
Department of Public Health & Human Services

November 2004

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Updated October 2001, December 2001, May 2002, June 2002, and September 2002, January 2003, August 2003, July 2004, November 2004.

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Key Contacts

Drug Prior Authorization

For all questions regarding drug prior authorization:

(800) 395-7961
(406) 443-6002 (Helena)
8:00 a.m. - 5:00 p.m. Monday - Friday
(Mountain time)

Mail backup documentation to:
Mountain-Pacific Quality
Healthcare Foundation
3404 Cooney Drive
Helena, MT 59602

Fax backup documentation to:
(800) 294-1350
(406) 443-7014 (Helena)

Point of Sale (POS) Help Desk

For assistance with on-line POS claims adjudication:
ACS, Atlanta
Technical POS Help Desk

(800) 365-4944
6:00 a.m - midnight, Monday - Saturday
10:00 a.m. - 9:00 p.m. Sunday
(Eastern time)

Program Policy

For program policy questions:
(406) 444-4540 (phone)
(406) 444-1861 (fax)
8:00 a.m. - 5:00 p.m. Monday - Friday
(Mountain time)

Send written inquiries to:
Medicaid Services Bureau
P.O. Box 202951
1400 Broadway
Helena, MT 59620

Paper Claims

Send paper claims to:
ACS Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Provider Relations

For questions about eligibility, payments, denials, general claims questions, or to request billing instructions:
(800) 624-3958 In state
(406) 442-1837 Out of state
8:00 a.m. - 5:00 p.m. Monday - Friday
(Mountain time)

Send written inquiries to:
ACS Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:
(800) 624-3958 In state
(406) 442-1837 Out of state
8:00 a.m. - 5:00 p.m. Monday - Friday

Send written inquiries to:
ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

Provider Enrollment

For enrollment changes or questions:
(800) 624-3958 In state
(406) 442-1837 Out of state
8:00 a.m. - 5:00 p.m. Monday - Friday

Send written inquiries to:
ACS Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Technical Services Center

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below and ask for the Medicaid Direct Deposit Manager.

(406) 444-9500

ACS EDI Gateway

For questions regarding your electronic remittance advice:

(800) 987-6719 Phone
(850) 385-1705 Fax

ACS EDI Gateway Services
2324 Killearn Center Blvd.
Tallahassee, FL 32309

Key Web Sites

Web Address	Information Available
State of Montana DPHHS Website www.dphhs.state.mt.us	• **General information about DPHHS:** Advisory councils, director's office, divisions and websites, goals and objectives, organizational charts, phone numbers, and policies and procedures • **Legal Information:** ADA commendation notice, ARM, Emergency notices, MAR, Other state and federal legal resources, proposed manual changes, requests for bids or proposals, requests for information • **News:** Bulletins, events calendar consumer product safety commission, meeting minutes, Montana Medicaid DUR board, press releases • **Services:** Applications and forms, guidelines, office locations, plans, programs available, publications, related website, reports, statistical information, virtual pavilion
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.state.mt.us	**Select *Human Services* for the following information:** • **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information. • **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • **DPHHS:** Latest news and events, Mental Health Services Plan information, program information, office locations, divisions, resources, legal information, and links to other state and federal web sites. • **Health Policy and Services Division:** Children's Health Insurance Plan (CHIP), Medicaid provider information such as manuals, newsletters, fee schedules, and enrollment information.
Provider Information web site www.mtmedicaid.org	• **Medicaid:** Medicaid provider information including provider manuals, fee schedules, notices and replacement pages, forms and frequently asked questions, newsletters, and key contacts. • **CHIP**: Information on the Children's Health Insurance Plan • **Public Health:** Disease prevention (immunizations), health and safety, health planning, and laboratory services • **Administration:** HPSD budgets, staff and program names and phone numbers, program statistics, and systems information. • **News:** Recent developments
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides
Washington Publishing Company www.wpc-edi.com	• EDI implementation guides • HIPAA implementation guides and other tools • EDI education

Drug Program

Drug Program Goal

The Prescription Drug Program covers pharmaceuticals and pharmacist services to clients served by the Department in the Medicaid program and the Mental Health Services Plan (MHSP).

Who may prescribe, administer, or dispense legend drugs and controlled substances?

Primary authority for the prescribing of legend drugs and controlled substances comes from individual professional practice acts, usually in the section of the act which defines the scope of practice for the profession. The definition of scope of practice is the responsibility of the board that licenses the professional.

DUE CARE Program

The DUE CARE (Drug Use Education, Concurrent and Retrospective Evaluation) program performs drug utilization review and educational interventions. Three pharmacists and three physicians comprise the DUE CARE Board which is coordinated by a full time registered Montana pharmacist. The DUE CARE Board meets monthly to review utilization and advise the Department.

The DUE CARE Board and The University of Montana School of Pharmacy also advise the Department on its outpatient drug formulary. Drugs are evaluated for safety, effectiveness, and clinical outcome. Drugs recommended for formulary exclusion have no significant, clinically meaningful therapeutic advantage over drugs recommended for inclusion.

DUE CARE Board meetings are posted on the DPHHS website under ***News, Montana Medicaid Drug Utilization Review Board*** (see *Key Contacts*).

Medicaid Covered Products

What drugs and pharmaceutical supplies are covered?

Federal regulations govern the coverage of pharmaceuticals manufactured by companies who have signed a federal rebate agreement including:

- Placing the drug onto the drug formulary.
- Requiring that the drug be prior authorized.
- Not covering certain drugs.

The Medicaid prescription drug program covers:

1. Legend drugs

2. Medicaid covers the following **prescribed** over-the-counter products manufactured by companies who have signed a federal rebate agreement:
   - Aspirin*
   - Insulin
   - Laxatives*
   - Antacids*
   - Head lice treatment
   - H2 antagonist GI products
   - Bronchosaline

   *Nursing facilities are responsible for providing over-the-counter laxatives, antacids and aspirin to their residents.

3. Vaccines except:
   - For children 18 years old and under, coverage is limited to vaccines **not** available directly to physicians and clinics through the Vaccines for Children (VFC) program.
   - For clients with Medicare Part B insurance, Medicaid excludes pneumonia and flu vaccines from coverage.

4. Compounded prescriptions

5. Contraceptive supplies and devices

What drugs and pharmaceutical supplies are not covered?

The Medicaid prescription drug program does not reimburse for the following items or services:

1. Drugs supplied by drug manufacturers who have not entered into a federal drug rebate agreement.

2. Drugs supplied by other public agencies such as the United States Veteran's Administration, United States Department of Health and Human Services, Indian Health Services, local health departments, etc.

3. Drugs prescribed:
   - To promote fertility
   - For weight reduction
   - For cosmetic purposes or hair growth
   - For an indication which is not medically accepted as determined by the Department in consultation with federal guidelines, DUE CARE, or the Department medical and pharmacy consultants.

4. Drugs designated as "less-than-effective" ("DESI" drugs), or which are identical, similar, or related to such drugs.

5. Prescription vitamins and mineral products in the absence of a condition that is clinically documented to produce a deficiency state, except prenatal vitamins and fluoride preparations. Prenatal vitamins are covered **only** when prescribed and dispensed to pregnant women.

6. Drugs that are experimental, investigational, or of unproven efficacy or safety

7. Free pharmaceutical samples

8. Obsolete National Drug Code (NDC)

9. Terminated drug products

10. Any drug, biological product, or insulin provided as part of, or incident to and in the same setting as, any of the following:
    - Inpatient hospital setting
    - Hospice services
    - Outpatient hospital services emergency room visit
    - Other laboratory and x-ray services
    - Renal dialysis

11. Any of the following drugs:
    - Outpatient nonprescription drugs
    - Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

12. Medical supplies (non-drug items) are not covered under the prescription drug program.

    Exception:
    - Contraceptive supplies and devices
    - Specific inhaler supplies

Mental Health Services Plan Covered Products

The Mental Health Services Plan

1. The Mental Health Services Plan (MHSP) formulary is limited to specific psychotropic and adjunct legend drugs. The formulary is shown in the following table.

2. The Department has rebate agreements with pharmaceutical manufacturers for many of the drugs on the formulary. Products with a signed rebate are considered a preferred drug. Products without a rebate agreement require a higher client cost sharing. Providers are asked to use rebated products to the extent possible. The manufacturers that have signed a rebate agreement are listed at the end of this chapter.

3. Clients are responsible for the following cost sharing:
   - Preferred generic drug $12.00/script
   - Preferred brand drug with generic available $12.00/script
   - Preferred brand drug with no generic available $12.00/script
   - All non-preferred drugs $17.00/script

4. Clozaril, all strengths, is exempt from cost sharing.

5. For clients with Mental Health Services Plan (MHSP) coverage, there is a $425 pharmacy cap. The MHSP program pays for the first $425 in prescriptions for the client each month, and the client must pay privately for any amounts over that cap.

6. Drug claims for the Mental Health Services Plan are processed through the same system used for Medicaid claims. To avoid confusion and claim denials, follow the instructions below:
   - **Point-of-Sale:** To submit MHSP claims, use Group Number **"0064206420"**
   - **Paper Claims:** Clearly write **"MHSP ONLY"** on the face of each paper claim

MHSP Formulary

Formulary Drug	PA Required	Rebate Available
Anti-anxiety Drugs		
alprazolam	N	Y
buspirone	Y	N
chlordiazepoxide	N	Y
clonazepam	N	Y
clorazepate dipotassium	N	Y
diazepam	N	Y
hydroxyzine	N	Y
lorazepam	N	Y
oxazepam	N	Y
Anti-psychotics		
aripiprazole (Abilify)	N	N
chlorpromazine	N	Y
clozapine (Clozaril)	N	Y
fluphenazine decanoate	N	Y
fluphenzine HCl	N	Y
haloperidol	N	Y
haloperidol decanoate	N	Y
haloperidol lactate	N	Y
loxapine HCl (Loxitane)	N	N
loxapine succinate	N	Y
mesoridazine besylate	N	N
molindone HCl (Moban)	N	N
olanzapine (Zyprexa)	N	N
perphenazine	N	Y

Formulary Drug	PA Required	Rebate Available
Anti-psychotics (continued)		
pimozide (Orap)	N	N
queltiapine fumarate (Seroquel)	N	N
risperidone (Risperdal)	N	N
thioridazine HCl	N	Y
thiothixene HCl	N	Y
trifluoperazine HCl	N	Y
ziprasidone HCl (Geodon)	N	Y
MAO Inhibitors		
phenelzine sulfate (Nardil)	N	N
tranylcypromine (Parnate)	N	N
Anti-depressants		
amitriptyline HCl	N	Y
bupropion (Wellbutrin, Wellbutrin SR)	N	Y
clomipramine HCl	N	Y
desipramine HCl	N	Y
doxepin	N	Y
imipramine HCl	N	Y
imipramine pamoate	N	Y
maprotiline HCl (Ludiomil)	Y	Y
mirtazapine (Remeron)	N	N
nefazodone (Serzone)	N	N
nortriptyline	N	Y

MHSP Formulary (continued)

Formulary Drug	PA Required	Rebate Available
Anti-depressants (continued)		
protriptyline	N	Y
trazodone	N	Y
venlafaxine (Effexor, Effexor XR)	N	Y
SSRIs		
citalopram hydrobromide (Celexa)	N	N
fluoxetine (Prozac)	N	N
fluvoxamine (Luvox)	N	Y
paroxetine HCl (Paxil)	N	N
sertraline (Zoloft)	N	Y
sertraline (Zoloft 50 mg)	Y	Y
Anti-mania Drugs		
lithium carbonate/citrate	N	Y
Non-barbiturate Sedative, Hypnotics		
diphenhydramine HCl (Benadryl)	N	Y
flurazepam HCl	N	Y
hydroxyzine pamoate (Vistaril)	N	Y
lorazepam	N	Y
temazepam (Restoril)	N	Y
triazolam	N	Y
zaleplon (Sonata)	Y	Y
zolpidem (Ambien)	Y	N

Formulary Drug	PA Required	Rebate Available
Anti-hyperkinesis/ Adrenergic Agents		
amphet asp/amphet/ d-amphet (Adderall)	N	N
atomoxetine HCI (Strattera)	N	N
dexmethylphenidate HCI (Focalin)	N	Y
d-amphetamine sulfate (Dexedrine)	N	N
methylphenidate HCl (Concerta)	N	Y
methylphenidate HCl (Ritalin)	N	Y
Anti-convulsants for adjunct therapy		
carbamazepine	N	Y
clonazepam	N	Y
divalproex sodium (Depakote)	N	Y
gabapentin (Neurontin)	Y	N
lamotrigine (Lamictal)	Y	Y
oxcarbazepine (Trileptal)	N	Y
topiramate (Topamax)	Y	N
valproic acid	N	Y
Anti-Parkinson Drugs		
amantadine	N	Y
benztropine mesylate	N	Y
trihexyphenidyl HCl	N	Y

MHSP Formulary (continued)

Formulary Drug	PA Required	Rebate Avail-able
Adrenergic Blocking Agents		
pindolol	Y	Y
propranolol	Y	Y
propranolol HCl	Y	Y
Miscellaneous Psychotherapeutic Agents		
clonidine	N	Y
clonidine patches (Catapres)	N	N
guanfacine	Y	Y
isradipine (DynaCirc)	Y	Y
levothyroxine sodium	Y	Y
liothyronine sodium	Y	Y
pemoline (Cylert)	N	Y
verapamil	Y	Y
verapamil HCl	Y	Y

Mental Health Services Plan Preferred Labelers
Alphabetical Listing

Manufacturer Name	Labeler Code	Manufacturer Name	Labeler Code
Abbott	00074	Novartis	00083
Able Laboratories Inc.	53265	Par Pharm	49884
Barr Laboratories Inc.	00555	Pfizer	00009
Celltech Pharmaceuticals	53014	Pfizer	00025
Elan	59075	Pfizer	00049
Esi Lederle	59911	Pfizer	00069
EON labs	00185	Pfizer	00071
Geneva	00781	Purepac Pharm	00228
Gensia Sicor Pharmaceuticals Inc.	00703	Qualitest Pharm	00603
GlaxoSmithKline	00007	Ranbaxy	63304
GlaxoSmithKline	00029	Roche	00004
Glaxo Smith Kline	00081	Roxane	00054
GlaxoSmithKline	00108	Solvay	00032
Glaxo Smith Kline	00173	Teva (Gate)	57844
Greenstone LTD - Pfizer Inc.	59762	Teva (Lemon)	00093
Ivax	00172	United Research Lab	00677
Ivax	00182	Upshire Smith	00832
Major Pharm	00904	Watson	00364
Mallinckrodt	00406	Watson	00591
MGP-Morton Grove Pharm	60432	Watson	52544
Mylan	00378	Wyeth Ayerst	00008
Novartis	00028	Wyeth Ayerst	00046
Novartis	00078		

Mental Health Services Plan Preferred Labelers
Numerical Listing

Labeler Code	Manufacturer Name	Labeler Code	Manufacturer Name
00004	Roche	00228	Purepac Pharm
00007	GlaxoSmithKline	00364	Watson
00008	Wyeth Ayerst	00378	Mylan
00009	Pfizer	00406	Mallinckrodt
00025	Pfizer	00555	Barr Laboratories Inc.
00028	Novartis	00591	Watson
00029	GlaxoSmithKline	00603	Qualitest Pharm
00032	Solvay	00677	United Research Lab
00046	Wyeth Ayerst	00703	Gensia Sicor Pharmaceuticals Inc.
00049	Pfizer	00781	Geneva
00054	Roxane	00832	Upshire Smith
00069	Pfizer	00904	Major Pharm
00071	Pfizer	49884	Par Pharm
00074	Abbott	52544	Watson
00078	Novartis	53014	Celltech Pharmaceuticals
00081	GlaxoSmithKline	53265	Able Laboratories Inc.
00083	Novartis	57844	Teva (Gate)
00093	Teva (Lemon)	59075	Elan
00108	GlaxoSmithKline	59762	Greenstone LTD - Pfizer Inc.
00172	Ivax	59911	Esi Lederle
00173	GlaxoSmithKline	60432	MGP-Morton Grove Pharm
00182	Ivax	63304	Ranbaxy
00185	EON Labs		

Dispensing Limitations

Prescription Quantity (ARM 37.86.1102)

1. Drugs are limited to a 34-day supply.

2. No more than two prescriptions of the same drug may be dispensed in a calendar month except for the following:
   - Antibiotics
   - Schedule II and III drugs
   - Antineoplastic agents
   - Compounded prescriptions
   - Prescriptions for suicidal patients or patients at risk for drug abuse
   - Topical preparations
   - Propoxyphene, propoxyphene napsylate, and all propoxyphene combinations

3. The DUE CARE board has set monthly limits on certain drugs. Use over these amounts requires prior authorization. Only one migraine medication may be prescribed within a month. Refer to the *Prior Authorization* chapter for limits.

Prescription Refills

Prescriptions may be refilled after 75% of the estimated therapy days have elapsed. The POS system will deny a claim for refill-too-soon based on prescriptions dispensed over a three-month period.

A prescription may be refilled early only if the prescriber changes the dosage, or if the client was admitted to a nursing facility. The Pharmacist must document any dosage change. In any circumstance, the provider must contact the Drug Prior Authorization Unit to receive approval (see *Key Contacts*).

Clients who experience difficulties in managing their drug therapy should be considered for use of unit dose prescriptions.

Generic Drugs

Prescribers and pharmacies must prescribe and dispense the generic form of a drug, whenever possible. Except for the drugs listed in the *Billing Procedures* chapter (*Dispense As Written (DAW)*), if the brand name drug is prescribed instead of a generic equivalent, the prescriber must get prior authorization. Authorization

is based on medical need such as adverse reactions (clinically demonstrated, observed and documented) which have occurred when the generic drug has been used.

Unit Dose Prescriptions

Pharmacy-packaged unit dose medications may be used to supply drugs to patients in nursing facilities, group homes, and other institutional settings.

Clients who are not in nursing facilities may also be considered high risk and eligible for unit dose packaging if they:

- have one or more of the following representative disease conditions: Alzheimer's disease, blood clotting disorders, cardiac arrhythmia, congestive heart failure, depression, diabetes, epilepsy, HIV/AIDS, hypertension, schizophrenia, or tuberculosis; **and**
- consume two or more prescribed concurrent chronic medications which are dosed at three or more intervals per day; **or**
- have demonstrated a pattern of noncompliance that is potentially harmful to their health.

Prior Authorization

Many drug products require prior authorization (PA) **before** the pharmacist provides them to the client. Requests are reviewed for medical necessity.

- To request prior authorization, providers must submit the information requested on the *Request for Drug Prior Authorization Form* to the Drug Prior Authorization Unit. This form is at the end of this document.
- The prescriber (physician, etc.) or pharmacy may submit requests by mail, telephone, or FAX to:

  Drug Prior Authorization Unit
  Mountain Pacific Quality Health Foundation
  3404 Cooney Drive
  Helena, MT 59602

  (406) 443-6002 or (800) 395-7961 (Phone)
  (406) 443-7014 or (800) 294-1350 (Fax)

- Requests are reviewed and decisions made immediately in most cases. Decisions on requests with special circumstances that require further peer review are made within 24 hours. Requests received after the PA Unit's regular working hours of 8 a.m. to 5 p.m. Monday through Friday, or on weekends or holidays are considered received at the start of the next working day.
- An emergency 72-hour supply may be dispensed for emergency after-hours/weekend/holiday requests. Payment will be authorized by using a "3" in the *days supply* field and a Medical Certification code of "8" in the *PA/MC code* field.

Prior Authorization for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, he or she should present the provider with an FA-455 (eligibility determination letter). Providers may choose whether or not to accept retroactive eligibility (see the *General Information For Providers* manual, *Client Eligibility* chapter). All prior authorization requirements must be met to receive Medicaid payment. When requesting PA, attach a copy of the FA-455 to the PA request. It is the client's responsibility to ensure his or her caseworker prepares an FA-455 for each provider who participates in the client's health care during this retroactive period. See the *Billing Procedures* chapter in the manual for retroactive eligibility billing requirements.

All prior authorization requirements must be met for retroactively eligible clients.

Medicaid PA Criteria

Drug	Criteria
Actiq Lozenges (fentanyl)	• No history of MAOI use within the last 30 days • Initial doses greater than 200mcg will not be approved. Initial therapy will be defined as patients not having Actiq therapy in the last 30 days • Non-cancer diagnoses will not be approved • Greater usage than 4 units of any strength per day • Authorization for existing usage in pain of non-cancer origin will be granted on an individual basis in consultation with the prescriber to prevent withdrawal syndromes.
Aggrenox (aspirin/dipyridamole)	For prevention of recurrent stroke in patients who have experienced a transient ischemic attack or previous ischemic stroke and who have had a recurrent stroke while on aspirin or have failed plavix.
Antiemetics Kytril Tablets and oral solution. PA required for quantities greater than 10 units in a 30-day period. Zofran Tablets and oral solution. PA required for quantities greater than 15 units in a 30-day period. Anzemet Tablets PA required for quantities greater than 5 units in a 30-day period.	For prescription exceeding monthly quantity limits for the prevention of nausea and vomiting associated with chemotherapy/radiation therapy, or for nausea and vomiting associated with pregnancy when traditional therapies have failed. Quantity limits for these and other indications will be considered on a case by case basis.
Antipsychotics Zyprexa Zydis (olanzapine) Risperdal M-tabs (risperidone)	Patients who have special requirements for administration of atypical antipsychotics may be granted prior authorization for these two formulations of Zyprexa and Risperdal.
Risperdal Consta (risperidone)	Prior authorization for Risperdal Consta, a long acting injectable form of Risperdal, requires that the patient must have tried and failed the oral Risperdal or have documented compliance issues.
Avinza (Morphine sulfate extended-release capsules) PA required for quantities greater than once daily.	Requests exceeding these quantity limits will be considered on an individual basis.

Medicaid PA Criteria (continued)

Drug	Criteria
COX-2 Inhibitors Celebrex (celecoxib) Bextra (valdecoxib)	No history of aspirin sensitivity or allergy to aspirin or other NSAID, and/or aspirin triad, and at least one of the following: • History of previous GI bleeding within the last 5 years • Current or recurrent gastric ulceration • History of NSAID-induced gastropathy • Currently treated for GERD • For clients 65 years of age • Currently on anticoagulant therapy
Dipyridamole	As adjunct to warfarin anticoagulants in the prevention of postoperative thromboembolic complications of cardiac valve replacement.

Disease-Modifying Anti-Rheumatic Drugs (DMARD)
 	
Arava (leflunomide)
Enbrel (etanercept)
Humira (adalimumab)
Kineret (anakinra)
Remicade (infliximab)
	• Diagnosis of rheumatoid arthritis
	• Rheumatology consult with date and copy of consult included
	• Kineret may be used alone or in combination with DMARD's other than tumor necrosis factor (TNF) blocking agents (i.e. Enbrel)
	  • Enbrel whether alone or in combination with methotrexate.
	  • Enbrel or Remicade may be approved with Arava on an individual basis.
	  • Remicade when used in combination with methotrexate may be approved for first-line treatment in patients with moderately to severely active rheumatoid arthritis as evidenced by:
	  • > 10 swollen joints
	  • ≥ 12 tender joints
	  • Elevated serum rheumatoid factor levels or erosions on baseline x-rays
	  • Remicade therapy will only be approved following a negative
	  • TB test
	  • Enbrel also covered for psoriasis when accompanied by a prescription from a dermatologist.

Remicade (infliximab)	Also covered for the following diagnoses: • Moderately to severely active Crohn's disease for patients with an inadequate response to conventional therapy • Fistulizing Crohn's disease
Erectile Dysfunction Viagra (sildenafil) Cialis (tadalafil) Levitra (vardenafil) Quantity limited to one (1) tablet per month	• Diagnosis of erectile dysfunction. • Males only, 18 years of age or older. • No concomitant organic nitrate therapy.

Medicaid PA Criteria (continued)

Drug	Criteria
Gastro-intestinal drugs Includes H-2 antagonists, proton pump inhibitors, and Cytotec Prior authorization is required only for concomitant usage of an H2-antagonist and a proton pump inhibitor. This PA requirement is designed to avoid therapeutic duplications.	Diagnosis of: • Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas) • Symptomatic gastroesophageal reflux (not responding or failure of maintenance therapy) • Symptomatic relapses (duodenal or gastric ulcer) on maintenance therapy • Barretts esophagus • GERD Other conditions considered on an individual basis.
Growth hormones	Diagnosis of: • Growth hormone deficiency in children and adults • Growth retardation of chronic renal insufficiency • Turner's Syndrome • AIDS-related wasting Children and adolescents must meet the following criteria: • Standard deviation of 2.0 or more below mean height for chronological age • No expanding intracranial lesion or tumor diagnosed by MRI • Growth rate below five centimeters per year • Bone age 14-15 years or less in females and 15-16 years or less in males • Epiphyses open **Growth hormone deficiency in children:** Failure of any two stimuli tests to raise the serum growth hormone level above 10 nanograms/ milliliter. **Growth retardation of chronic renal insufficiency:** Irreversible renal insufficiency with a creatinine clearance <75 ml/min per 1.73m^2 but pre-renal transplant. Turner's Syndrome: Chromosomal abnormality showing Turner's syndrome. Growth hormone deficiency in adults: • **Adult Onset:** Patients have somatotropin deficiency syndrome (SDS) either alone or with multiple hormone deficiencies, (hypopituitarism), as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma. • **Childhood Onset:** Patients who had growth hormone deficient during childhood and now have somatotropin deficiency syndrome (SDS).

Medicaid PA Criteria (continued)

Drug	Criteria
Hypnotic Drugs Ambien (zolpidem) Sonata (zaleplon) Quantity limited to 15 tablets per month.	Trial and failure with at least <u>two</u> multi-source prescription sleep-inducing drugs.
Migraine Headache Drugs For monthly quantities greater than 9 tablets: Imitrex (sumatriptan): 4 injections (2 kits) **or** 6 units of nasal spray Maxalt (rizatriptan) Zomig (zolmitriptan) and Zomig ZMT (zolmitriptan) Zomig nasal spray 6 units Migranal (dihydroergotamine): 4 units Axert (almotriptan) Frova (frovatriptan) Relpax (electriptan) Amerge (naratriptan HCl)	Indicated only for treatment of <u>acute</u>, migraine/cluster headache attacks for patients who meet the following criteria: • No history of, or signs or symptoms consistent with, ischemic heart disease (angina pectoris, history of MI or documented silent ischemia) or Prinzmetal's angina • No uncontrolled hypertension • No complicated migraine including vertebrobasilar migraine • Not pregnant • No use of ergotamine-containing medication(s) within previous 24-hours • No use of MAOI within previous 2-weeks • Non-responsive to NSAIDS, acetaminophen, combination analgesics (isometheptene, butalbital, +/- metoclopramide), or ergot derivatives, or these medications are contraindicated Usage of duplicating generic entities are not allowed, but authorization may be approved on an individual basis for concomitant use of differing dosing formulations of the same drug. Concurrent therapy with Stadol will not be covered.
Nonsedating antihistamine products	• Prescribed OTC Loratadine products whose manufacturer has a rebate agreement with the Centers for Medicare and Medicaid Services (CMS) will be available to clients without prior authorization (PA) restrictions. • PA required for federal legend brand and generic non-sedating antihistamines. PA may be authorized upon failure of a fourteen day trial of OTC Loratadine products
Nonsteroidal Anti-Inflammatory Drugs (NSAIDS) PA required for all single-source NSAIDS: Ponstel Mobic Naprelan	Trial and failure with at least <u>two</u> multiple-source products must be documented.
Oxycodone HCL Controlled-Release (OxyContin)	Prior authorization is required for all dosing above twice a day and above 320 mg per day.

Medicaid PA Criteria (continued)

Drug	Criteria
Pletal (cilostazol) For greater than 12-week supply within a 12-month period.	• Diagnosis of intermittent claudication as the result of chronic occlusive arterial disease (COAD) of the lower limbs. Possible causes of COAD include: arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's disease), arteritis, trauma, congenital arterial narrowing, or other forms of peripheral vascular disease resulting in chronic vascular occlusion in the legs; **and** • The patient has shown clinical improvement in their COAD while on pentoxifylline or cilostazol. • Considered on an individual basis when pentoxifylline or cilostazol is being used as part of a standardized treatment protocol, e.g. bone marrow or oncology treatment protocols.
Proton Pump Inhibitors (PPI's) Prevacid NapraPac	Federal legend, brand and generic Proton Pump Inhibitors (PPI's) may be authorized upon failure of Prilosec OTC 20mg at doses that exceed 40mg per day. Special consideration may be given on an individual basis for patients requiring specific dosing regimens based on the various PPI formulations. Requires that the patient must have tried and failed concomitant use of Prilosec OTC and Naproxen.
Smoking Cessation Drugs Nicotine-replacement products. Patches are the preferred course of therapy. The gum, lozenge and inhaler replacement therapies are only authorized for patients having allergies or intolerance to the patch adhesive. Zyban (buproprion)	Authorization given for 4-month course of therapy. Four trials of therapy are allowed.
Stadol (butorphanol) PA required for quantities greater than 3 - 2.5 ml metered dose spray pumps within a one-month period	Indicated for management of pain including post-operative analgesia or acute migraine headache pain for patients who meet the following criteria: • No history of hypersensitivity to butorphanol or any components of the product • No history of narcotic dependency or abuse • Not pregnant • No ulcerations of the nasal mucosa • No history of psychological or neurological disorder • No history of head trauma within the previous 7 days • 18 years of age or older • Non-responsive to NSAIDS, acetaminophen, combination analgesics (isometheptene, butalbital, +/- metoclopramide), or ergot derivatives, or these medications are contraindicated.

Medicaid PA Criteria (continued)

Drug	Criteria
Thalomid (thalomide)	Treatment of the cutaneous manifestations of moderate-to-severe erythema nodosum leprosum (ENL). Considered for other diagnoses on individual basis.
Toradol (ketorolac) For quantity greater than a 5-day supply within a month	Indicated for the short-term treatment of acute pain. Authorization considered on an individual basis.
Tretinoin PA required for patients 26 years and older.	Diagnose of: • Skin cancer • Lamellar ichthyosis • Darier-White disease • Psoriasis • Severe recalcitrant (nodulocystic) acne
Xanax XR (alprazolam extended-release tables)	• Xanax XR tables may be covered for patients who have not responded to adequate trials of at least two generic long-acting benzodiazepines, one of which is generic alprazolam. • Coverage of Xanax XR will be allowed for once daily dosing only.
Zoloft 25 mg & 50 mg (sertraline)	Authorized for patients requiring dosages where tab splitting would be inappropriate (i.e., 75 mg, 125 mg).
Zyvox (linezolid)	Adult patients with vancomycin-resistant enterococcus.

MHSP Prior Authorization Criteria	
Drug	**Criteria**
buspirone (Buspar)	• Augumentation of depression and/or obsessive compulsive disorder (OCD). • Generalized anxiety disorder.
zaleplon (Sonata) zolpidem (Ambien)	Trial and failure with at least **two** multi-source prescription sleep-inducing drugs.
amotrigine (Lamictal)	• Diagnosis of bi-polar disorder.
guanfacine (Tenex) isradipine (DynaCirc) levothyroxine sodium (Synthroid) liothyronine sodium (Cytomel) pindolol (Visken) propranolol HCl (Inderal) verapamil, verapamil HCl (Calan)	Use as augmentation strategy specifically related to mental health treatment.
maprotiline HCl (Ludiomil)	Considered on an individual basis.
sertraline (Zoloft 25 mg & 50 mg)	Authorized for patients requiring dosages where tablet splitting would be inappropriate (i.e., 75 mg, 125 mg).
gabapentin (Neurontin)	Must specify if anxiety (generalized anxiety, panic disorder, post traumatic stress disorder) and/or compelling reason with bipolar disorder.
topiramate (Topamax)	Diagnosis of bipolar disorder, obesity, intolerance, time effective of Lithium, Depakote, Trileptal/Tegretol.
Antipsychotics Zyprexa Zydis (olanzapine) Risperdal M-tabs (risperidone)	Patients who have special requirements for administration of atypical antipsychotics may be granted prior authorization for these two formulations of Zyprexa and Risperdal.
Risperdal Consta (risperidone)	Prior authorization for Risperdal Consta, a long acting injectable form of Risperdal, requires that the patient must have tried and failed the oral Risperdal or have documented compliance issues.

MOUNTAIN-PACIFIC QUALITY HEALTH FOUNDATION

Request for Drug Prior Authorization

Submitter: ☐ Physician ☐ Pharmacy **Please Type or Print**

PATIENT NAME (Last) (First) (Initial)		PATIENT MEDICAID I.D. NUMBER	DATE OF BIRTH		
			MONTH	DAY	YEAR
PHYSICIAN PROVIDER #	PHYSICIAN PHONE #	DATES COVERED BY THIS REQUEST			
		FROM		TO	
PHYSICIAN NAME		MONTH DAY YEAR		MONTH DAY YEAR	
PHYSICIAN STREET ADDRESS		**MAIL, FAX OR PHONE COMPLETED FORM TO:**			
PHYSICIAN CITY STATE ZIP		**DRUG PRIOR AUTHORIZATION UNIT MOUNTAIN-PACIFIC QUALITY HEALTH 3404 COONEY DRIVE HELENA, MT 59602 (406) 443-6002 or 1-800-395-7961 (PHONE) (406) 443-7014 or 1-800-294-1350 (FAX)**			
PHARMACY PROVIDER NO.	PHARMACY PHONE #				
PHARMACY NAME					
PHARMACY STREET ADDRESS					
PHARMACY CITY STATE ZIP					

DRUG TO BE AUTHORIZED

DRUG NAME	STRENGTH	DIRECTIONS

DIAGNOSIS OR CONDITION TREATED BY THIS DRUG

LEAVE BLANK - PA UNIT USE ONLY

REASON FOR DENIAL OF DRUG PRIOR AUTHORIZATION

IMPORTANT NOTE: In evaluating requests for prior authorization, the consultant will consider the drug from the standpoint of published criteria only. If the approval of the request is granted, this does not indicate that the recipient continues to be eligible for Medicaid. It is the responsibility of the provider of service to establish by inspection of the recipient's Medicaid eligibility card and if necessary, by contact with Consultec to determine if the recipient continues to be eligible for Medicaid.

CURRENT RECIPIENT ELIGIBILITY MAY BE VERIFIED BY CALLING CONSULTEC AT 1-800-624-3958 or 406-442-1837.

APPROVAL OR DENIAL STATUS	DENIAL CODE	THERAPEUTIC CLASS	AUTH ID	DATE OF REQUEST	PRIOR AUTHORIZATION NUMBER

Reimbursement

Reimbursement for covered drugs

Reimbursement for covered drugs is the lessor of:

- The provider's usual and customary charge
- The estimated acquisition cost (EAC) plus a dispensing fee
- The maximum allowable cost (MAC) plus a dispensing fee

Usual and customary

The usual and customary charge is the price the provider most frequently charges the general public for the same drug. In determining "usual and customary" prices, the Department:

- Does not include prescriptions paid by third party payers, including health insurers, governmental entities, and Montana Medicaid, in the "general public".
- Includes discounts advertised or given (including but not limited to cash rebate, monetary price discount, coupon of value) to any segment of the general public.
- Uses the lower of the two pricing policies if a provider uses different pricing for "cash" and "charge" clients.
- Will use the median price if during an audit, the most frequent price cannot be determined from pharmacy records.

Estimated acquisition cost (EAC)

- The EAC is the Department's best estimate of providers' cost for a drug in the package size most frequently purchased.
- The Department uses the average wholesale price (AWP) less 15 percent as their EAC; **or**
- The Department may set an allowable acquisition cost when the department determines that acquisition cost is lower than AWP less 15 percent.

Maximum allowable cost (MAC)

- The MAC reimbursement applies to a listing of specific, therapeutically equivalent multiple-source drugs with ample availability.

- The MAC is based on the Federal Upper Limit pricing set by U.S. Department of Health and Human Services Centers for Medicare and Medicaid (CMS).
- Brand name and generic drugs with a MAC established price are reimbursed at the MAC price unless the physician or other licensed practitioner certifies in their own handwriting that in their medical judgement a specific brand name drug is medically necessary for a particular patient.
- Prior authorization for a brand name drug when a generic drug is available must be obtained from the Drug Prior Authorization Unit except for the drugs listed in the *Billing Procedures* chapter, *Dispense As Written (DAW)*.

Dispensing fee

- The maximum dispensing fee is $4.70 for in-state pharmacies and $3.50 for out-of-state pharmacies.
- New pharmacy providers are assigned an interim dispensing fee of $3.50 until a dispensing fee survey can be completed for a six-month period of operation.
- Pharmacies may receive an additional $0.75 for dispensing pharmacy-packaged unit dose prescriptions.
- Dispensing fee surveys are available from the Department of Public Health and Human Services Prescription Drug Program (see *Key Contacts*).

The Remittance Advice

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* in this chapter). Each line of the RA represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

Electronic RA

Providers may receive the RA electronically as an ANSI ASC X12N 835 transaction, or through the Internet on the Montana Eligibility and Payment System (MEPS). For more information on X12N 835 transactions, see the Companion Guides available on the ACS EDI Gateway website and the Implementation Guides on the Washington Publishing Company website (see *Key Contacts*).

MEPS is available through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form;* see *Payment and the RA* within this chapter). After this form has been processed, you will receive a password. Entry into the system requires a valid

provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

RAs are available from MEPS in PDF and a flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the "SOR Download" page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks. For more information on MEPS, see *Payment and the RA* later in this chapter.

Paper RA

The paper RA is divided into the following sections: RA notice, paid claims, denied claims, pending claims, credit balance claims, gross adjustments, and reason and remark codes and descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.

Sections of the Paper RA

Section	Description
RA notice	The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.
Paid claims	This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter).
Denied claims	This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter.
Pending claims	All claims that have not reached final disposition will appear in this area of the paper RA (pended claims are not available on X12N 835 transactions). The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied. Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.
Credit balance claims	Credit balance claims are shown here until the credit has been satisfied.
Gross adjustments	Any gross adjustments performed during the previous cycle are shown here.
Reason and remark code description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

(1)

LOCAL PHARMACY
2100 NORTH MAIN STREET
WESTERN CITY MT 59988

(2) PROVIDER# 0001234567 (3) REMIT ADVICE #123456 (4) WARRANT # 654321 (5) DATE:02/15/03 PAGE 2 (6)

RECIP ID (7)	NAME (8)	SERVICE DATES FROM	TO (10)	UNIT OF SVC (11)	PROCEDURE REVENUE NDC (12)	TOTAL CHARGES (13)	ALLOWED (14)	CO-PAY (15)	EOB CODES (16)
PAID CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	013103	013103	28	63653117101	106.53	90.02	Y	
(9) ICN	40204011250000700	PRESCRIPTION # 0012345							
		LESS COPAY DEDUCTION					2.00		
		CLAIM TOTAL*******				106.53	88.02 (17)		
DENIED CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	020303	020303	56	00597005801	110.74	0.00	N	31MA61
ICN	40204011250000800	PRESCRIPTION # 0012345					(17)		
		CLAIM TOTAL*******				110.74			

**********THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE**********

31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

Key Fields on the Remittance Advice

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The 7-digit number assigned to the provider by Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. Internal control number (ICN)	Each claim is assigned a unique 17-digit number (ICN). The MMIS converts the 14-digit TCN to an ICN. Use this number when you have any questions concerning your claim. The claim number represents the following information: 0 00111 00 123 000123 A B C D E A = Claim medium 0 = Paper claim 4 = Electronic claim B = Julian date (e.g. April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number
10. Service dates	Date(s) services were provided. If service(s) were performed in a single day, the same date will appear in both columns
11. Unit of service	The units of service rendered under this procedure or NDC code.
12. Procedure/revenue/NDC	The procedure code (CPT, HCPCS, or local), National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount a provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Copay	A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.
16. Reason/Remark Codes	A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, billed amount, and paid amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Credit balances

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

Credit balances can be resolved in two ways:

1. By "working off" the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual. Depending on switch-vendor requirements, some point-of-sale adjustments must be completed within three months. In this case, adjustments may be submitted on paper within the timely filing limits.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or requesting Provider Relations to complete a gross adjustment.

Rebilling Medicaid

Rebilling is when a provider submits a claim (or claim line) to Medicaid that was previously submitted for payment but was either returned or denied. Pharmacy providers can rebill Medicaid via point-of-sale or on paper. Paper claims are often returned to the provider before processing because key information such as NABP number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* and *Completing a Claim* chapters.

When to rebill Medicaid

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the Explanation of Benefits (EOB) code, make the appropriate corrections, and resubmit the claim (not an adjustment).
- ***Line Denied.*** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. Either submit the denied service on a new MA-5 form, or cross out paid lines and resubmit the form, or submit via point-of-sale. Do not use an adjustment form.
- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

How to rebill

- Check any EOB code listed and make your corrections on a copy of the claim, or produce a new claim with the correct information, or rebill using point-of-sale.
- When making corrections on a copy of the claim, remember to cross out or omit all lines that have already been paid. The claim must be neat and legible for processing.
- Enter any insurance (TPL) information on the corrected claim, or attach insurance denial information to the corrected claim, and send it to Claims Processing (see *Key Contacts*).

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see *Billing Procedures, Claim Inquiry*). Once an incorrect payment has been verified, the provider may submit an *Individual Adjustment Request* form (in *Appendix A*) to Provider Relations or submit an adjustment through point-of-sale. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th

digit will be a 2, indicating an adjustment. See *Key Fields on the Remittance Advice* earlier in this chapter. Adjustments are processed in the same time frame as claims.

When to request an adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (such as client ID, NABP number, date of service, NDC, prescribing provider, units, etc.).

How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in *Appendix A*. Adjustments may also be made using point-of-sale. The requirements for adjusting a claim are as follows:

- Claims Processing must receive individual claim adjustment requests within 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each TCN.
- If you are correcting more than one error per TCN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section of the adjustment form.

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:
This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS: Local Pharmacy
Name: 123 Medical Drive
Street or P.O. Box: Anytown, MT 59999
City State Zip
2. CLIENT NAME: Jane Doe
3. INTERNAL CONTROL NUMBER (ICN): 00204011250000600
4. PROVIDER NUMBER: 1234567
5. CLIENT ID NUMBER: 123456789
6. DATE OF PAYMENT: 02/15/03
7. AMOUNT OF PAYMENT $: 11.49

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service	Line 2	2	28
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)	Line 3	02/01/03	01/23/03
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: John R. Smith DATE: 04/15/03

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

Sample Adjustment Request

Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A*. You may also order forms from Provider Relations or download them from the *Provider Information* web site (see *Key Contacts*). Complete Section A first with provider and client information and the claim's TCN number (see following table and sample RA).
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
   - Enter the date of service or the line number in the *Date of Service or Line Number* column.
   - Enter the information from the claim that was incorrect in the *Information on Statement* column.
   - Enter the correct information in the column labeled *Corrected Information*.

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider name and address	Provider's name and address (and mailing address if different).
2. Recipient name	The client's name is here.
3.* Internal control number (ICN)	Enter the TCN number. There can be only one TCN per adjustment request form. When adjusting a claim that has been previously adjusted, use the TCN of the most recent claim.
4.* Provider number	The provider's NABP number.
5.* Recipient Medicaid number	Client's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice field #5 (see the sample RA earlier in this chapter).
7. Amount of payment	The amount of payment from the remittance advice field #17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/ NDC/ Revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (Nursing facility)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

3. Attach copies of the RA and a corrected claim if necessary.
   - If the original claim was billed electronically, a copy of the RA will suffice.
   - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit balance or a check from the provider (see *Credit balances* earlier in this chapter).
- Any questions regarding claims or adjustments must be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments by a Provider Notice or on the first page of the remittance advice (RA Notice section). Mass adjustment claims shown on the RA have an ICN that begins with a "4" (see *Key Fields on the Remittance Advice* earlier in this chapter).

Payment and The RA

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

Electronic Funds Transfer

With EFT, the Department deposits the funds directly in the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A) (see the following table). One form must be completed for each provider number.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. For questions or changes regarding EFT, contact the Technical Services Center and ask for the Medicaid Direct Deposit Manager (see *Key Contacts*).

Electronic Remittance Advice

To receive an electronic RA, the provider must be enrolled in electronic funds transfer and have Internet access. You can access your electronic RA through the Montana Eligibility and Payment System (MEPS) on the Internet through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form* (see the following table).

After this form has been processed, you will receive a password. Entry into the system requires a valid provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

RAs are available from MEPS in PDF and a flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the "SOR Download" page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks.

Required Forms For EFT and/or Electronic RA

All three forms are required for a provider to receive weekly payment

Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows provider to receive electronic remittance advices on MEPS (must also include MEPS Access Request form)	• Provider Information website (see *Key Contacts*) • Provider Relations	Provider Relations (see *Key Contacts*)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	• Provider Information website (see *Key Contacts*) • Provider's bank	Provider Relations (see *Key Contacts*)
MEPS Access Request Form	Allows provider to receive a password to access their RA on MEPS	• Provider Information website (see *Key Contacts)* • Virtual Human Services Pavilion • Direct Deposit Manager of the DPHHS Technical Services Center	DPHHS address on the form

Other Programs

The information in this chapter also applies to the Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP) vision and dental services only.

Billing Procedures

Provider Number

- The Department uses the pharmacy's NABP (National Association of Board of Pharmacy) assigned number as the provider number for billing purposes.
- The Department-assigned provider number is used for payment and reporting purposes.
- Changes in pharmacy ownership or NABP number must be reported immediately to ensure that payments are received by the billing owner. Contact ACS Provider Relations to report all ownership changes:

ACS Provider Enrollment
P.O. Box 4936
Helena, MT 59604

(800) 624-3958
(406) 442-1837

How long do I have to bill?

Providers are required to submit a clean claim no later than 365 days from:

- the date of service;
- the date retroactive eligibility is determined;
- the date disability is determined; or
- within 6 months of the date Medicare pays, whichever is later.

A "clean claim" is one that can be adjudicated without correction, additional information, or documentation from the provider.

Tips to avoid timely filing denials

- Correct and resubmit denied claims promptly (see the *Reimbursement* chapter, *Remittance Advices and Adjustments* section in this manual).
- If a claim submitted to Medicaid does not appear on the remittance advice within 30 days, contact Provider Relations for claim status (see *Key Contacts*).

When To Bill Medicaid Clients (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid clients for services covered under Medicaid. The main exception is that providers may collect cost sharing from clients.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled client who was accepted as a Medicaid client by the provider, even if the claim was denied.

Under certain circumstances, providers may need a signed agreement in order to bill a Medicaid client (see the following table).

When to Bill a Medicaid Client (ARM 37.85.406)

	• **Client Is Medicaid Enrolled** • **Provider Accepts Client as a Medicaid Client**	• **Client Is Medicaid Enrolled** • **Provider Does Not Accept Client as a Medicaid Client**	• **Client Is Not Medicaid Enrolled**
Service is covered by Medicaid	Provider can bill client **only** for cost sharing	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client
Service is not covered by Medicaid	Provider can bill client only if custom agreement has been made between client and provider before providing the service	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client

Routine Agreement: This may be a routine agreement between the provider and client which states that the client is not accepted as a Medicaid client, and the he or she must pay for the services received.

Custom Agreement: This agreement lists the service the client is receiving and states that the service is not covered by Medicaid and that the client will pay for it.

Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (Eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the service(s) and bill Medicaid for the service(s). For more information on retroactive eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Usual and Customary Charge (ARM 37.85.406)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service.

Client Cost Sharing (ARM 37.85.204 and 37.85.402)

Clients are responsible for cost sharing for Medicaid-covered prescriptions to a maximum of $25 per month.

For the prescription drug program, cost sharing is as follows:

- 5% of the Medicaid allowed amount with a minimum of $1.00 and a maximum of $5.00 per prescription.

The following drugs are exempt from cost sharing:

- Clozaril, all strengths
- Family planning prescriptions
- Compounded prescriptions for infusion therapy

The following are exempt from cost sharing:

- Clients under 21 years of age
- Pregnant women (until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed)
- Nursing facility residents
- Clients with third party liability (TPL) when Medicaid is the secondary payer.

To exempt cost sharing on POS, enter a "4" in the *PA/MC code & Number* field. On a paper claim enter a "4" in *Drug Name* field. See Chapter 8 *POS* and Chapter 9 *Completing a Paper Claim*.

For clients with Mental Health Services Plan (MHSP) coverage, there is a $425 pharmacy cap. The MHSP program pays for the first $425 in prescriptions for the client each month, and the client must pay privately for any amounts over that cap.

Providers may choose to collect client cost sharing at the time of service or bill the client later. According to federal regulation, a provider cannot deny services to a Medicaid client due to the client's inability to pay cost sharing at the time services are rendered. However, the client's inability to pay cost sharing at the time services are rendered does not lessen the client's obligation to pay cost sharing.

National Drug Codes (NDC)

All outpatient prescription drugs are billed using the drug's NDC, the 11-digit code assigned to all prescription drug products by the labeler or distributor of the product under FDA regulations.

The Department accepts only the 5-4-2 NDC format. All 11 digits, including zeros, must be entered. The three segments of the NDC are:

The provider must always use the complete 11-digit NDC from the dispensing container.

SAMPLE NDC: 12345-6789-10
12345 = labeler code
6789 = product code
10 = package size

Claims must accurately report the NDC dispensed, the number of units dispensed, days supply, and the date of dispensing. Use of an incorrect NDC or inaccurate reporting of a drug quantity will cause the Department to report false data to drug manufacturers billed for drug rebates.

The Department will recover payments made on erroneous claims discovered during dispute resolution with drug manufacturers. Pharmacies are required to document purchase for quantities of brands of drugs reimbursed by the Department if disputes occur.

Dispense As Written (DAW)

Prescribers and pharmacies must prescribe and dispense the generic form of a drug whenever possible. Except for those drugs listed below, prior authorization is required when a brand name drug is prescribed instead of a generic equivalent. Please use the following DAW codes for these situations:

- DAW 1 may only be used only if authorized by the Drug Prior Authorization Unit.
- DAW 5 may be used in instances where the drug dispensed is generic but is listed as a brand (Branded Generics).
- DAW 7 may be used for the following drugs without prior authorization:

  - Lanoxin/Lanoxicaps
  - Coumadin
  - Ritalin
  - Anti-hemophiliac factors
  - Thyroid medications
  - Tegretol
  - Cyclosporine products (i.e. Neoral, Sandimmune)
  - Clozaril
  - Dexedrine products
  - Cylert
  - Imuran
  - Adderal
  - Dilantin
  - Depakote

- In addition to prior authorization requirements, brand name drugs with a generic equivalent may be billed only when the prescriber has handwritten "Brand Necessary" or "Brand Required" on the prescription. The pharmacy must retain brand certifications as documentation.

Compounded Prescriptions

Infusion Therapy Compounded Drugs

- Use the individual NDC for each drug product used.
- Exempt cost sharing. (To exempt cost sharing on POS, enter a "4" in the *PA/MC code & Number* field. On a paper claim enter a "4" in *Drug Name* field. See Chapter 8 *POS* and Chapter 9 *Completing a Paper Claim*.)

Routine, Non-infusion Compounded Drugs

Use the Department-assigned NDCs as follows:

Medication	NDC
Bowel Preparations	00888-0001-00 through 00888-0001-02
Compounded oral tablet, capsule or solution	00888-0002-00 through 00888-0002-29
Injectable (non-infusion)	00888-0003-00 through 00888-0003-02
Nasal Preparation	00888-0004-00 through 00888-0004-02
Ophthalamic Preparations	00888-0005-00 through 00888-0005-02
Otic Preparations	00888-0006-00 through 00888-0006-02
Respiratory Preparations	00888-0007-00 through 00888-0007-09
Suppositories & Suspensions	00888-0008-00 through 00888-0008-12
Topical creams, ointments and gels	00888-0009-00 through 00888-0009-29
Topical Solutions	00888-0010-00 through 00888-0010-02

POS Billers: Use a "0" or "1" in the Compound Code field. Do **not** use a "2".

Abuse and Misutilization

The following practices constitute abuse and misutilization:

1. **Excessive Fees** (commonly known as *prescription splitting* or *incorrect* or *excessive dispensing fees*)**:** Billing inappropriately in order to obtain dispensing fees in excess of those allowed by:
   - Supplying medication in amounts less than necessary to cover the period of the prescription.

- Supplying multiple medications in strengths less than those prescribed to gain more than one dispensing fee.

2. **Excessive Filling:** Billing for an amount of a drug or supply greater than the prescribed quantity.

3. **Prescription Shorting:** Billing for drug or supply greater than the quantity actually dispensed.

4. **Substitution to Achieve a Higher Price:** Billing for a higher priced drug than prescribed even though the prescribed lower priced drug *was* available.

Point-of-Sale

What is the pharmacy point-of-sale (POS)?

The point-of-sale (POS) system finalizes claims at the point-of-entry as either "paid" or "denied." The POS system uses the National Council for Prescription Drug Programs (NCPDP) version 3.2C format.

Do pharmacies have to use point-of-sale?

Using a POS system is **not** required. Claims may be submitted through hard copy (paper) billing or electronically using the Department's approved record formats. All claims are processed and edited through the POS system regardless of how they are submitted.

Do pharmacies need a separate agreement with the Department to use POS?

No! A separate agreement with the Department is not required to use POS. Simply contact your software or switch vendor. Pharmacies arrange their own telecommunication switch services and are responsible for any charges imposed by these vendors as switching fees.

What if client eligibility is not shown in POS?

If the Medicaid client presents a valid Medicaid ID card and the POS system denies the claim due to eligibility, the pharmacy may fill the prescription and submit the claim online at a later time. The Medicaid program will support the payment of these prescriptions, provided the services are covered by the program and the pharmacy maintains a copy of the valid Medicaid card.

POS Help Desk

For questions or problems with the POS system, contact the ACS-Atlanta Help Desk:

1-800-365-4944
POS Help Desk

If the claim continues to deny for eligibility past three (3) working days, call ACS Provider Relations at:
1-800-624-3958
or
406-442-1837

PRO-DUR

The POS system performs all major prospective drug utilization review (PRO-DUR) edits. In some circumstances, the PRO-DUR edits result in denied claims. When a PRO-DUR denied claim needs to be overridden, pharmacy providers may enter one DUR Conflict Code (see following table) from each category in the following order, as long as the indicated situations exist and the pharmacy retains documentation in its files:

1. Two byte alpha DUR Conflict Code, *followed by* . . .

2. Two byte alphanumeric DUR Intervention Code, *followed by* . . .

3. Two byte alphanumeric DUR Outcome Code

By placing codes into the claim, the provider is certifying that the indicated DUR code is true and documentation is on file. For questions regarding DUR codes, contact the Drug Prior Authorization Unit.

NCPDP DUR Codes

DUR Conflict Code	Description
AT	Additive Toxicity
CH	Call POS Help Desk
DA	Drug Allergy Alert
DC	Inferred Drug Disease Precaution
DD	Drug-Drug Interaction
DI	Drug Incompatibility
DL	Drug Lab Conflict
DP	Drug Food Conflict
DS	Tobacco Use Precaution
ER	Overuse Precaution
HD	High Dose Alert
IC	Iatrogenic Condition Alert
ID	Ingredient Duplication
LD	Low Dose Alert
LR	Under Use Alert
MC	Drug Disease Precaution
MN	Insufficient Duration Alert
MX	Excessive Duration Alert
OH	Alcohol Precaution
PA	Drug Age Precaution
PG	Drug Pregnancy Precaution
PR	Prior Adverse Reaction
SE	Side Effect Alert
SX	Drug Gender Alert
TD	Therapeutic Duplicaiton

DUR Interven-tion Code	Description
M0 (M,Zero)	MD Interface
P0 (P,Zero)	Patient Interaction
R0 (R,Zero)	Pharmacist Reviewed

DUR Outcome Code	Description
1A	Filled, False Positive
1B	Filled as is
1C	Filled with Different Dose
1D	Filled with Different Directions
1E	Filled with Different Drug
1F	Filled with Different Quantity
1G	Filled after Prescriber Approval Obtained
2A	Not Filled
2B	Not Filled, Directions Clarified

MONTANA MEDICAID PAYER SHEET

Effective January 12, 2004

Montana Medicaid

BIN # :	610084
DESTINATION:	ACS, Inc./CONSULTEC
ACCEPTING:	CLAIM ADJUDICATION AND CLAIM REVERSALS
FORMAT:	NCPDP 3C

1. Data Elements NCPDP 3C

HEADER INFORMATION						
FIELD NUMBER	NAME OF FIELD	FORMAT	FIELD LENGTH	START POSITION	VALID VALUE / FORMAT	REQUIRED STATUS
101	Bin Number	N	6	1	61ØØ84	Required
102	Version/Release Number	A/N	2	7	3C	Required
103	Transaction Code	N	2	9	Ø1-Ø4 Rx Billing 11 Rx Reversal 24 Rx Downtime Billing 31-34 Rx Re-Billing	Required
104	Processor Control Number	A/N	8	11	DRRXPRODMT - For Production claims DRRXACCPMT - For test claims (IF USING WEBMD/ENVOY SWITCH REFER TO WEBMD/ENVOY FOR PCN)	Required
201	Pharmacy Number	A/N	12	21	7 digit NCPDP/NABP number	Required
301	Group Number	A/N	15	33	1509040	Required
302	Cardholder ID Number	A/N	18	48	Medicaid ID Number as found on the Medicaid ID card	Required
303	Person Code	A/N	3	66		Optional
304	Date of Birth	N	8	69	CCYYMMDD	Optional
305	Sex Code	N	1	77	1 = Male 2 = Female 3 = Unspecified	Optional
306	Relationship Code	N	1	78		Optional
308	Other Coverage Code	N	1	79	0 = Not specified 1 = No other coverage exists 2 = Other coverage exists – payment collected 3 = Other coverage exists – this claim not covered 4 = Other coverage exists – Payment not collected	Required
401	Date Filled	N	8	80	CCYYMMDD	Required
310	Patient First Name	A/N	12	100		Optional
311	Patient Last Name	A/N	15	115		Optional

CLAIM INFORMATION						
FIELD NUMBER	NAME OF FIELD	FORMAT	FIELD LENGTH	START POSITION	VALID VALUE / FORMAT	REQUIRED STATUS
402	Prescription Number	N	7	131		Required
403	New/Refill Code	N	2	138	ØØ = New Prescription Ø1 to 99 = Number of Refill	Required
404	Metric Quantity	N	5	140		Not used
405	Days Supply	N	3	145	Estimated number of days the prescription will last.	Required
406	Compound Code	N	1	148	Compound medications may be billed using dummy NDCs in the range 00888-0330-00 through 0888-0330-99.	Optional
407	NDC Number	N	11	149		Required
408	Dispense as Written (DAW)	A/N	1	160	Only code '1' is accepted. This field is only required when billing for a brand name drug that has a generic equivalent	Required
409	Ingredient Cost	D	6	161	s$$$$cc	Required
411	Prescriber ID	A/N	10	167	DEA #, if the DEA # is unknown – use the first 9 characters of the prescriber's last name	Required
414	Date Prescription Written	N	8	177	CCYYMMDD	Required
426	Usual & Customary Charge	D	6	185	s$$$$cc Should include the pharmacy professional fee, if applicable.	Required
416	Prior Authorization / Medical Certification Code and Number	N	12	194	VNNNNNNNNNNN V = Medical Certification Code (Must be left justified in the full field N= PA number. A '4' is required if the patient is exempt from copayment, pregnancies, family planning prescriptions and emergencies. All under age 21 recipients and Nursing Home recipient exemptions are automatically set by the system.	Optional
429	Unit Dose Indicator	N	1	223	'3' = in –house unit dosed prescribed	Optional
431	Other Payor Amount	D	6	224	S$$$cc – used for TPL	Conditional
439	DUR Conflict Code	A/N	2	263		Optional
440	DUR Intervention Code	A/N	2	268		Optional
441	DUR Outcome Code	A/N	2	273		Optional
443	Primary Payor Denial Date	N	8	275	CCYYMMDD Required when Other Coverage Code equal 2,3,4. The payment or denial date is entered in this field.	Conditional

Other Information

- An optional data element means that the user should be prompted for the field but does not have to enter a value.
- Duplicate claims will be rejected with an 83 error (claim has been paid)
- DUR information, if applicable, will appear in the message text of the response
- **Compound Code –** All compound prescriptions must be billed with dummy NDC numbers from 00888-0330-00 through 00888-0330-99.

- **Dispense as Written –** This field is only required whenever billing for brand name drugs that have generic equivalents.

- **PA/MC Code and Number –** A ‘4’ is required if the patient is exempt from copayment due to pregnancies, family planning prescriptions and emergencies. All under age 21 recipients and Nursing Home recipient exemptions are automatically set by the system.

NCPDP VERSION 5 PAYER SHEET – B1/B3 Transactions

****GENERAL INFORMATION****

Payer Name: Montana Medicaid	Date: January 1, 2004
Plan Name/Group Name: Montana Medicaid / Montana Mental Health Services Program (MHSP)	
Processor: ACS	Help Desk: 800-365-4944
Effective: 10/01/2003	Version/Release #: 5.1
Contact/Information Source: ACS Helpdesk	

**** OTHER TRANSACTIONS SUPPORTED ****

Transaction Code	Transaction Name
B1	**Billing**
B3	**ReBill**

BILLING TRANSACTION:

Transaction Header Segment: Mandatory in all cases

Field #	*NCPDP Field Name/length*	*Value*	*M/R/RW*	*Comment*
1Ø1-A1	BIN Number	61ØØ84	M	
1Ø2-A2	Version/Release Number	51	M	Version Supported
1Ø3-A3	Transaction Code	B1 = Billing B2 = Reversals B3 = Rebill	M	What type of transaction is being sent
1Ø4-A4	Processor Control Number	DRMTPROD = Production DRMTACCP = Test	M	This is the same for MT Mental Health
1Ø9-A9	Transaction Count	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	M	5.1 accepts up to 4 transactions per transmissions, this is where the pharmacy indicates how many are being submitted
2Ø2-B2	Service Provider ID Qualifier	Ø7=NCPDP Provider ID	M	NCPDP is the NABP number
2Ø1-B1	Service Provider ID	NCPDP Provider number	M	NCPDP is the NABP number
4Ø1-D1	Date of Service	CCYYMMDD	M	
11Ø-AK	Software Vendor/Certification ID	ØØØØØØØØØØ	M	If no number is supplied, populate with zeros

-

Patient Segment: Optional

Field	*NCPDP Field Name*	*Value*	*M/R/RW*	*Comment*
111-AM	Segment Identification	Ø1	M	Patient Segment
331-CX	Patient ID Qualifier	Blank = Not Specified Ø1=Social Security Number Ø2=Driver's License Number Ø3=U.S. Military ID 99=Other	NA	Not used by Montana
332-CY	Patient ID		NA	Not used by Montana
3Ø4-C4	Date of Birth	CCYYMMDD	NA	Not used by Montana

3Ø5-C5	Patient Gender Code	Ø=Not specified 1=Male 2=Female	NA	Not used by Montana
31Ø –CA	Patient First Name		NA	Not used by Montana
311 – CB	Patient Last Name		NA	Not used by Montana
322-CM	Patient Street Address		NA	Not used by Montana
323-CN	Patient City Address		NA	Not used by Montana
324-CO	Patient State/Province Address		NA	Not used by Montana
325-CP	Patient Zip/POSTAL Zone		NA	Not used by Montana
326-CQ	Patient Phone Number		NA	Not used by Montana
3Ø7-C7	Patient Location	Ø=Not specified 1=Home 2=Inter-Care 3=Nursing Home 4=Long Term/Extended Care 5=Rest Home 6=Boarding Home 7=Skilled Care Facility 8=Sub-Acute care Facility 9=Acute Care Facility 10=Outpatient 11=Hospice	NA	Not used by Montana
333-CZ	Employer ID	Used with Commercial plans	NA	Not used by Montana.
334-1C	Smoker/Non-Smoker Code	Blank=Not Specified 1=Non-Smoker 2=Smoker	NA	Not used by Montana
335-2C	Pregnancy Indicator	Blank=Not Specified 1=Not pregnant 2=Pregnant	RW	Required when submitting a claim for a pregnant member

Insurance Segment: Mandatory

Field #	*NCPDP Field Name*	*Value*	*M/R/RW*	*Comment*
111-AM	Segment Identification	Ø4	M	Insurance Segment
3Ø2-C2	Cardholder ID	Use client's 9-digit ID number	M	
312-CC	Cardholder First Name		NA	Not used by Montana
313-CD	Cardholder Last Name		NA	Not used by Montana
314-CE	Home Plan		NS	**Not Supported**
524-FO	Plan ID		NA	Not used by Montana.
3Ø9-C9	Eligibility Clarification Code	Ø=Not specified 1=No Override 2=Override 3=Full Time Student 4=Disabled Dependent 5=Dependent Parent 6=Significant Other	NA	Not used by Montana
336-8C	Facility ID	ID assigned to the patient's clinic/host party.	NS	**Not Supported**
3Ø1-C1	Group ID	For Medicaid use 15Ø9Ø4Ø For MHSP use ØØ642Ø642Ø	R	
3Ø6-C6	Patient Relationship Code	1 = Cardholder 2 = Spouse 3=Child 4=Other	NA	Not used by Montana
3Ø3-C3	Person code		RW	Always 'Ø1' when entry is required by your system Used to identify family member

Claim Segment: Mandatory

Field #	*NCPDP Field Name*	*Value*	*M/R/RW*	*Comment*
111-AM	Segment Identification	Ø7	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	1 = Rx Billing	M	
4Ø2-D2	Prescription/Service Reference Number		M	Number assigned by the pharmacy
436-E1	Product/Service ID Qualifier	Ø3 = National Drug Code	M	
4Ø7-D7	Product/Service ID	NDC Number	M	
456-EN	Associated Prescription/Service Reference #		RW	Used when submitting a claim for a completion fill
457-EP	Associated Prescription/Service Date		RW	Used when submitting a claim for a completion fill
458-SE	Procedure Modifier Count		NA	Not used by Montana
459-ER	Procedure Modifier Code Count		NA	Not used by Montana
442-E7	Quantity Dispensed	Metric Decimal Quantity	R	
4Ø3-D3	Fill Number	Ø= Original Dispensing 1-99 = Number of refills	R	
4Ø5-D5	Days Supply		R	There is a maximum of a 34 day supply allowed for MT providers
4Ø6-D6	Compound Code	Ø = Not specified 1= Not a compound **2 = Compound**	RW	Required when submitting a claim for a multi-line compound

408-D8	Dispense as Written (DAW)	**1=Physician request** **5=brand used as generic** **7=brand mandated by law**	RW	MT providers can use valid values 1, 5 and 7 for DAW overrides
414-DE	Date Prescription Written	CCYYMMDD	R	
415-DF	Number of Refills Authorized	Ø=Not Specified 1-99=number of refill	NA	Not used by Montana
419-DJ	Prescription Origin Code	Ø=Not specified 1=Written 2=Telephone 3=Electronic 4=Facsimile	NA	Not used by Montana
42Ø-DK	Submission Clarification Code	Ø=Not specified, default 1=No override 2=Other override 3=Vacation Supply 4=Lost Prescription 5=Therapy Change 6=Starter Dose 7=Medically Necessary **8=Process compound for Approved Ingredients** 9=Encounters 99=Other	RW	Provider may submit when submitting a claim for a multi-line compound that includes a non-covered ingredient. Montana only uses Valid Value '8'
46Ø-ET	Quantity Prescribed		NS	Not Used, use 442-E7
3Ø8-C8	Other Coverage Code	Ø=Not Specified 1=No other Coverage Identified 2=Other coverage exists-payment collected 3=Other coverage exists-this claim not covered 4=Other coverage exists-payment not collected 5=Managed care plan denial 6=Other coverage exists, not a participating provider 7=Other Coverage exists-not in effect at time of service 8=Claim is a billing for a copay	R	
429-DT	Unit Dose Indicator	Ø=Not specified 1=Not Unit Dose 2=Manufacturer Unit Does **3=Pharmacy Unit Does**	RW	Ø3 required when in house unit dose
453-EJ	Orig Prescribed Product/Service ID Qual	Ø1=Universal Product Code (UPC) Ø3=National Drug Code (NDC)	NA	Not used by Montana
445-EA	Originally Prescribed Product/Service Code		NA	Not used by Montana
446-EB	Originally Prescribed Quantity		NA	Not used by Montana
330-CW	Alternate ID		NS	Not supported
454-EK	Scheduled prescription ID Number		NS	Not Supported
418-DI	Level of Service		NA	Not used by Montana

461-EU	Prior Authorization Type Code	Ø=Not Specified 1=Prior Authorization 2=Medical Certification 3=EPSDT (Early Periodic Screening Diagnosis Treatment) **4=Exemption from Copay** 5=Exemption from RX 6=Family Plan. Indic. 7=AFDC (Aid to Families with Dependent Children) **8=Payer Defined Exemption**	RW	Code clarifying the 'Prior Authorization Number' (462-EV). Replaced PA/MC Field **4** is used for co-pay exemptions **8** can be use for up to a 3 day emergency supply
462-EV	Prior Authorization Number Submitted		NA	Replaced PA/MC Field
463-EW	Intermediary Authorization Type ID		NA	Not used by Montana
464-EX	Intermediary Authorization ID		NA	No used by Montana
343-HD	Dispensing Status	P = Partial Fill C = Completion Fill	RW	Required when submitting a claim for a partial fill
344-HF	Quantity Intended to be Dispensed		RW	Required when submitting a claim for a partial fill
345-HG	Days Supply Intended to be Dispensed		RW	Required when submitting a claim for a partial fill
6ØØ-28	Unit of Measure		NS	Not Supported

Pharmacy Provider Segment: Not used by Montana Medicaid or Mental Health Services Program

Field #	*NCPDP Field Name*	*Value*	*M/R/RW*	*Comment*
111-AM	Segment Identification	Ø2	M	Pharmacy Provider Segment
465-EY	Provider ID Qualifier	Blank=Not specified Ø1=Drug Enforcement Administration (DEA) Ø2=State License Ø3=Social Security Number (SSN) Ø4=Name Ø5=National Provider Identifier (NPI) Ø6=Health Industry Number (HIN) Ø7=State Issued 99=Other	NA	Not used by Montana
444-E9	Provider ID		NA	Not used by Montana

Prescriber Segment: Required for Montana Pharmacy Providers

Field #	*NCPDP Field Name*	*Value*	*M/R/RW*	*Comment*
111-AM	Segment Identification	Ø3	M	Prescriber Segment
466-EZ	Prescriber ID Qualifier	12=Drug Enforcement Administration (DEA)	R	
411-DB	Prescriber ID	DEA Number	R	Use DEA number, if not known, call the POS help desk.
467-1E	Prescriber Location Code		NS	Not Supported
427-DR	Prescriber Last Name		NA	Not used by Montana
498-PM	Prescriber Phone Number		NA	Not used by Montana

468-2E	Primary Care Provider ID Qualifier	Blank=Not Specified Ø1=National Provider ID (NPI) Ø2=Blue Cross Ø3=Blue Shield Ø4=Medicare **Ø5=Medicaid** Ø6=UPIN Ø7=NCPDP Provider ID Ø8=State License Ø9=Champus 1Ø=Health Industry Number (HIN) 11=Federal Tax ID 12=Drug Enforcement Administration (DEA) 13=State Issued 14=Plan Specific 99=Other	NA	Use 'Ø5' for Medicaid and MT Mental Health.
421-DL	Primary Care Provider ID		NA	Not used by Montana
469-H5	Primary care Provider Location Code		NS	Not Supported
47Ø-4E	Primary Care Provider Last Name		NS	Not Supported

COB/Other Payments Segment:

Field #	*NCPDP Field Name*	*Value*	*M/R/RW*	*Comment*
111-AM	Segment Identification	Ø5	M	COB/Other Payments Segment
337-4C	Coordination of Benefits/Other Payments Count	Count of other payment occurrences.	M	1,2,etc
338-5C	Other Payer Coverage Type	Blank=Not Specified Ø1=Primary Ø2=Secondary Ø3=Tertiary 98=Coupon 99=Composite	M (Repeating)	Code identifying the type of 'Other Payer ID' (34Ø-7C).
339-6C	Other Payer Id Qualifier	Blank=Not Specified Ø1=National Payer ID Ø2=Health Industry Number Ø3=Bank Information Number (BIN) Ø4=National Association of Insurance Commissioners (NAIC) Ø9=Coupon 99-Other	NA	Not used by Montana Medicaid
340-7C	Other Payer ID		NA	Not used by Montana Medicaid
443-E8	Other Payer Date	CCYYMMDD	RW	
341-HB	Other Payer Amount Paid Count		RW	
342-HC	Other Payer Amount Paid Qualifier	Blank=Not specified Ø1=Delivery Ø2=Shipping Ø3=Postage Ø4=Administrative Ø5=Incentive Ø6=Cognitive Service Ø7=Drug Benefit Ø8=Sum of all Reimbursement 98=Coupon 99=Other	RW (Repeating)	
431-DV	Other Payer Amount Paid		RW	
471-5E	Other Payer Reject Count		NA	Not used by Montana Medicaid

472-6E	Other Payer Reject Code		NA	Not used by Montana Medicaid

Workers' Compensation Segment: Not used by Montana Medicaid or Mental Health Services Program

Field #	*NCPDP Field Name*	*Value*	*M/R/RW*	*Comment*
111-AM	Segment Identification	Ø6	NA	Workers' Compensation Segment
434-DY	Date of Injury		NA	Not used by Montana
315-CF	Employer Name		NA	Not used by Montana
316-CG	Employer Street Address		NA	Not used by Montana
317-CH	Employer City Address		NA	Not used by Montana
318-CI	Employer State/Province ID		NA	Not used by Montana
319-CJ	Employer Zip/Postal Zone		NA	Not used by Montana
320-CK	Employer Phone Number		NA	Not used by Montana
321-CL	Employer Contact Name		NA	Not used by Montana
327-CR	Carrier ID		NA	Not used by Montana
435-DZ	Claim/Reference ID		NA	Not used by Montana

DUR/PPS Segment: Optional

Field #	*NCPDP Field Name*	*Value*	*M/R/RW*	*Comment*
111-AM	Segment Identification	Ø8	M	DUR/PPS Segment
473-7E	DUR/PPS Code counter		M	Required when submitting this segment
439-E4	Reason for Service Code	See Attached list of valid values	RW	Required when a service need to be explained
44Ø-E5	Professional Service Code	See Attached list of valid values	RW	Required when there has been a professional service
441-E6	Result of Service Code	See attached list of valid values	RW	Required when there has been an outcome because of services rendered
478-8E	DUR/PPS Level of Effort	Ø=Not Specified 11=Level 1 (Lowest) 12=Level 2 13=Level 3 14=Level 4 15=Level 5 (Highest)	NA	Not used by Montana
475-J9	DUR Co-Agent ID Qualifier		NA	Not used by Montana
476-H6	DUR Co-Agent ID		NA	Not used by Montana

Pricing Segment: Mandatory

Field #	*NCPDP Field Name*	*Value*	*M/R/RW*	*Comment*
111-AM	Segment Identification	11	M	Pricing Segment
4Ø9-D9	Ingredient Cost Submitted		R	Required by ACS
412-DC	Dispensing Fee Submitted		NA	Not used by Montana
477-BE	Professional Service Fee Submitted		NA	Not used by Montana
433-DX	Patient Paid Amount Submitted		NA	Not used by Montana
481-HA	Flat Sales Tax Amount Submitted		NA	Not used by Montana

482-GE	Percentage Sales Tax Amount Submitted		NA	Not used by Montana
484-JE	Percentage Sales Tax Basis Submitted	Blank=Not specified Ø1=Gross Amount Due Ø2=Ingredient Cost Ø3=Ingredient Cost + Dispensing Fee	NA	Not used by Montana
426-DQ	Usual and Customary Charge		R	
430–DU	Gross Amount Due		R	
423-DN	Basis of Cost Determination	Blank=Not specified ØØ=Not specified Ø1=AWP (Average Wholesale Price) Ø2=Local Wholesaler Ø3=Direct Ø4=EAC (Estimated Acquisition Cost) Ø5=Acquisition Ø6=MAC (Maximum Allowable Cost) Ø7=Usual & customary Ø9=Other	NA	Not used by Montana

Coupon Segment: Segment is not supported – Not used by Montana Medicaid or Mental Health Services Program

Field #	*NCPDP Field Name*	*Value*	*M/R/RW*	*Comment*
111-AM	Segment Identification	Ø9	NS	Coupon Segment
485-KE	Coupon Type		NS	
486-ME	Coupon Number		NS	
487-NE	Coupon Value Amount		NS	

Compound Segment: Optional

Field #	*NCPDP Field Name*	*Value*	*M/R/RW*	*Comment*
111-AM	Segment Identification	1Ø	M	Compound Segment
45Ø-EF	Compound Dosage Form Description Code	Ø1=Capsule Ø2=Ointment Ø3=Cream Ø4=Suppository Ø5=Powder Ø6=Emulsion Ø7=Liquid 1Ø=Tablet 11=Solution 12=Suspension 13=Lotion 14=Shampoo 15=Elixir 16=Syrup 17=Lozenge 18=Enema	M	Dosage form of the complete compound mixture.
451-EG	Compound Dispensing Unit Form Indicator	1=Each 2=Grams 3=Milliliters	M	NCPDP standard product billing codes

452-EH	Compound Route of Administration	1=Buccal 2=Dental 3=Inhalation 4=Injection 5=Intraperitoneal 6=Irrigation 7=Mouth/Throat 8=Mucous Membrane 9=Nasal 1Ø=Ophthalmic 11=Oral 12=Other/Miscellaneous 13=Otic 14=Perfusion 15=Rectal 16=Sublingual 17=Topical 18=Transdermal 19=Translingual 2Ø=Urethral 21=Vaginal 22=Enteral	M	Code for the route of administration of the complete compound mixture.
447-EC	Compound Ingredient Component (Count)		M (Repeating)	Count of compound product IDs (both active and inactive) in the compound mixture submitted.
488-RE	Compound Product ID Qualifier	Ø3=National Drug Code (NDC)	M (Repeating)	
489-TE	Compound Product ID		M (Repeating)	
448-ED	Compound Ingredient Quantity		M (Repeating)	
449-EE	Compound Ingredient Drug Cost		NA	
49Ø -UE	Compound ingredient basis of Cost Determination	Blank=Not specified Ø1=AWP Ø2=Local Wholesaler Ø3=Direct Ø4=EAC Ø5=Acquisition Ø6=MAC Ø7=Usual & customary Ø9 =Other	NA	

Prior Authorization Segment: Not used by Montana Medicaid or Mental Health Services Program

Field #	*NCPDP Field Name*	*Value*	*M/R/RW*	*Comment*
111-AM	Segment Identification	12	NA	Prior Authorization Segment
498-PA	Request Type	1=Initial 2=Reauthorization 3=Deferred	NA	Not used by Montana
498-PB	Request Period Date –Begin		NA	Not used by Montana
498-PC	Request Period Date- End		NA	Not used by Montana
498-PD	Basis of Request	ME=Medical Exception PR=Plan Requirement PL=Increase Plan Limitation	NA	Not used by Montana
498-PE	Authorized Representative First Name		NA	Not used by Montana
498-PF	Authorized Representative Last Name		NA	Not used by Montana
498-PG	Authorized Representative Street Address		NA	Not used by Montana
498-PH	Authorized Representative City Address		NA	Not used by Montana

498-PJ	Authorized Representative State/Province Address		NA	Not used by Montana
498-PK	Authorized Representative Zip/Postal Code		NA	Not used by Montana
498-PY	Prior Authorization Number Assigned		NA	Not used by Montana
503-F3	Authorization Number		NA	Not used by Montana
498-PP	Prior Authorization Supporting Documentation	Free Text field	NA	Not used by Montana

Clinical Segment: Not Used by Montana Medicaid or Mental Health Services Program

Field #	*NCPDP Field Name*	*Value*	*M/R/RW*	*Comment*
111-AM	Segment Identification	13	NA	Clinical Segment
491-VE	Diagnosis Code Count		NA	Not used by Montana
492-WE	Diagnosis Code		NA	Not used by Montana
424-DO	Diagnosis Code		NA	Not used by Montana
493-XE	Clinical Information Counter		NA	Not used by Montana
494-ZE	Measurement Date		NA	Not used by Montana
495-H1	Measurement Time		NA	Not used by Montana
496-H2	Measurement Dimension		NA	Not used by Montana
497-H3	Measurement Unit		NA	Not used by Montana
499-H4	Measurement Value		NA	Not used by Montana

Additional Claim Information

DUR Codes

Reason for Service Codes (DUR Conflict Codes)

AD=Additional Drug Needed
AN=Prescription Authentication
AR=Adverse Drug Reaction
AT=Additive Toxicity
CD=Chronic Disease Management
CH=Call Help Desk
CS=Patient Complaint/Symptom
DA=Drug-Allergy
DC=Drug-Disease (Inferred)
DD=Drug-Drug Interaction
DF=Drug-Food interaction
DI=Drug Incompatibility
DL=Drug-Lab Conflict
DM=Apparent Drug Misuse
DS=Tobacco Use
ED=Patient Education/Instruction
ER=Overuse
EX=Excessive Quantity
HD=High Dose
IC=Iatrogenic Condition
ID=Ingredient Duplication
LD=Low Dose
LK=Lock In Recipient
LR=Underuse
MC=Drug-Disease (Reported)
MN=Insufficeint Duration
MS=Missing Information/Clarification
MX=Excessive Duration
NA=Drug Not Available
NC=Non-covered Drug Purchase

ND=New Disease/Diagnosis
NF=Non-Formulary Drug
NN=Unnecessary Drug
NP=New Patient Processing
NR=Lactation/Nursing Interaction
NS=Insufficient Quantity
OH=Alcohol Conflict
PA=Drug-Age
PC=Patient Question/Concern
PG=Drug-Pregnancy
PH=Preventive Health Care
PN=Prescriber Consultation
PP=Plan Protocol
PR=Prior Adverse Reaction
PS=Product Selection Opportunity
RE=Suspected Environmental Risk
RF=Health Provider Referral
SC=Suboptimal Compliance
SD=Suboptimal Drug/Indication
SE=Side Effect
SF=Suboptimal Dosage Form SR=Suboptimal Regimen
SX=Drug-Gender
TD=Therapeutic Duplication
TN=Laboratory Test Needed
TP=Payer/Processor Question

Professional Service Codes (Intervention Codes)

M0 = MD Interface R0 = Pharmacist Reviewed
P0 = Patient Interaction

Result of Service Codes (DUR Outcome Codes)

ØØ=Not Specified
1A=Filled As Is, False Positive
1B=Filled Prescription As Is
1C=Filled, With Different Dose
1D=Filled, With Different Directions
1E=Filled, With Different Drug
1F=Filled, With Different Quantity
1G=Filled, With Prescriber Approval
1H=Brand-to-Generic Change
1J=Rx-to-OTC Change
1K=Filled with Different Dosage Form
2A=Prescription Not Filled
2B=Not Filled, Directions Clarified
3A=Recommendation Accepted
3B=Recommendation Not Accepted
3C=Discontinued Drug
3D=Regimen Changed
3E=Therapy Changed
3F=Therapy Changed-cost increased acknowledged
3G=Drug Therapy Unchanged
3H=Follow-Up/Report
3J=Patient Referral
3K=Instructions Understood
3M=Compliance Aid Provided
3N=Medication Administered

Completing a Paper Claim

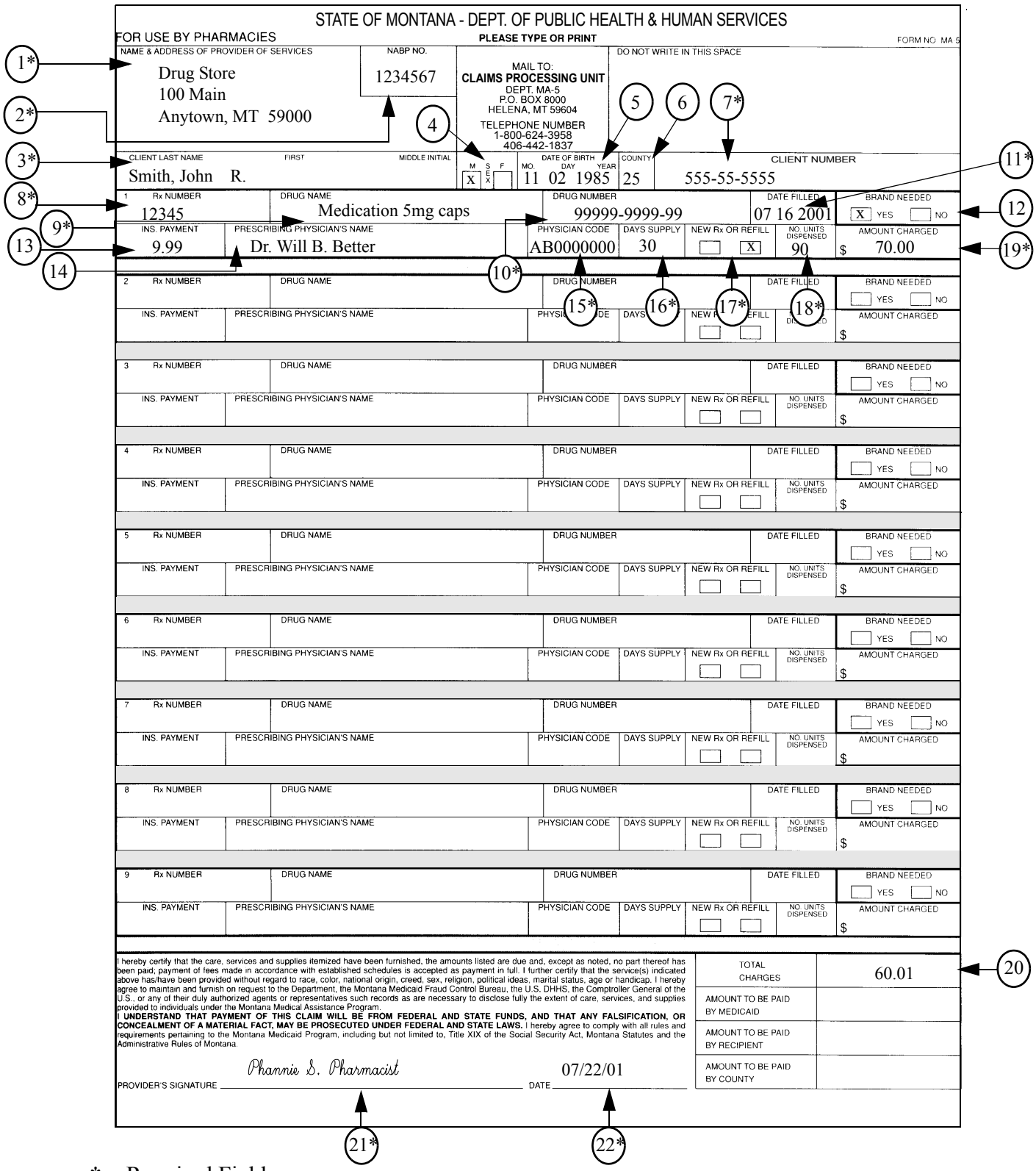
Completing Pharmacy Claim Form – MA-5

- The information needed to complete the Pharmacy Claim Form MA-5 is described below. Required fields are indicated by "*".
- For MHSP claims, clearly write "**MHSP ONLY**" on the face of each paper claim.
- Paper claims must be mailed to the following address:

ACS Claims Processing Unit
P.O. Box 8000
Helena, MT 59604

Field	Field Title	Instructions
1*	Name & Address of provider of services	Enter the pharmacy name and address.
2*	NABP Number	Enter the pharmacy's 7-digit NABP number.
3*	Client Name	Enter the client's last name, first name, and middle initial.
4	Sex	Enter the client's gender.
5	Date of Birth	Enter the client's date of birth in MMDDYYYY form.
6	County	Enter the client's county. (See *Montana County Listing.)*
7*	Client Number	Enter the client's 9-digit ID number.
8*	Rx Number	Enter the pharmacy-assigned prescription number.
9*	Drug Name	Enter the name of the drug. For a unit dose prescription, enter the words "UNIT DOSE". For a cost sharing exempt prescription, enter a "4". If DAW 1, 5, or 7 is used, indicate here.
10*	Drug Number	Enter the manufacturer's 11 digit NDC from the dispensing container.
11*	Date Filled	Enter the date the prescription is filled in MMDDYYYY form.
12	Brand Needed	Check "Y" and indicate DAW 1, 5, or 7 when physician has certified "Brand Necessary" or "Brand Required," or the drug is a "Branded Generic," and the following conditions are met: • DAW 1 requires prior authorization. • DAW 5 if the brand is generic but listed as a brand. • DAW 7 for those drugs listed in the *Billing Procedures* chapter, *Dispense As Written (DAW)*.
13	Insurance Payment	Enter any third party payments received by pharmacy. If patient has a Medicaid incurment, enter the incurment payment.
14	Prescribing Physician Name	Enter the prescriber's name.
15*	Physician Code	Enter the prescriber's DEA number.
16*	Days Supply	Enter the days supply of medication dispensed.
17*	New Rx or Refill	Indicate new or refill prescription.
18*	Number of Units Dispensed	Enter the quantity (metric) dispensed. (Use decimal form when applicable. (0.00))
19*	Amount Charged	Enter the pharmacy's usual and customary charge including dispensing fee.
20	Total Charges	Enter total charges of all claims on form.
21*	Provider's Signature	Claims must contain the provider's or authorized agent's signature, a facsimile of stamped signature or a computer generated name.
22*	Date	Enter the date signed.

Sample Paper Claim Form (MA-5)



* = Required Field

Montana County Listing

Number	County
01	Beaverhead
02	Big Horn
03	Blaine
04	Broadwater
05	Carbon
06	Carter
07	Cascade
08	Chouteau
09	Custer
10	Daniels
11	Dawson
12	Deer Lodge
13	Fallon
14	Fergus
15	Flathead
16	Gallatin
17	Garfield
18	Glacier
19	Golden Valley
20	Granite
21	Hill
22	Jefferson
23	Judith Basin
24	Lake
25	Lewis & Clark
26	Liberty
27	Lincoln
28	Madison
29	McCone

Number (continued)	County (continued)
30	Meagher
31	Mineral
32	Missoula
33	Musselshell
34	Park
35	Petroleum
36	Phillips
37	Pondera
38	Powder River
39	Powell
40	Prairie
41	Ravalli
42	Richland
43	Roosevelt
44	Rosebud
45	Sanders
46	Sheridan
47	Silver Bow
48	Stillwater
49	Sweet Grass
50	Teton
51	Toole
52	Treasure
53	Valley
54	Wheatland
55	Wilbaux
56	Yellowstone

Definitions

This section contains definitions, abbreviations, and acronyms used in these billing instructions which relate to the Medicaid Prescription Drug Program.

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

Authorization
An official approval for action taken for, or on behalf of, an eligible Medicaid client. This approval is only valid if the client is eligible on the date of service.

Authorized Prescriber
A physician, osteopath, dentist, nurse, physician assistant, optometrist, naturopath, or other person duly authorized by law or rule in the State of Montana to prescribe drugs.

Average Wholesale Price (AWP)
The average wholesale price of a drug product from wholesalers nationwide at a point in time. The Department uses the AWP as reported by First Data Bank.

Brand Name
The proprietary or trade name selected by the manufacturer and placed upon a drug, its container, label, or wrapping at the time of packaging.

Code of Federal Regulations (CFR)
The general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Client
An applicant for, or recipient of, DPHHS medical care programs.

Coinsurance
The client's financial responsibility for a medical bill as assigned by Medicaid/Medicare (usually a percentage). Medicaid coinsurance is usually 5% of the Medicaid allowed amount, and Medicare coinsurance is usually 20% of the Medicare allowed amount.

Compounding
The act of combining two or more active ingredients or adjusting therapeutic strengths in the preparation of a prescription.

Cost sharing
The client's financial responsibility for a medical bill, usually in the form of a copayment (flat fee) or coinsurance (percentage of charges).

Covered Outpatient Drug
A drug approved for safety and effectiveness as a prescription drug under the federal Food, Drug, and Cosmetic Act, and manufactured or distributed by manufacturers/labelers who have signed a drug rebate agreement with the federal Department of Health and Human Services (DHHS).

Department
The state Department of Public Health and Human Services (DPHHS).

DESI
(Drug Efficacy Study Index) or "less than effective drugs")
An index that measures one drug against a clinical response criteria. If the index is low, the drug is classified as less than effective.

Dispense
The interpretation of a prescription or order for a legend drug and, pursuant to that prescription or order, the proper selection, measuring, compounding, labeling, or packaging necessary to prepare that prescription or order for delivery.

Dispensing Fee
A fee set by the Department to reimburse pharmacies for their administrative costs incurred in filling prescriptions for clients.

Drug Formulary
A list, developed by the DUE CARE Board, of outpatient drugs covered by the Prescription Drug Program, including products with limited coverage and requiring prior authorization.

Drug Utilization Review (DUR) Program
A quality assurance program for covered outpatient drugs which assures that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

Estimated Acquisition Cost (EAC)
The department's best estimate of the price providers generally and currently pay for a drug marketed or sold by a particular manufacturer or labeler in the package size most frequently purchased by providers.

Explanation of Medicare Benefits (EOMB)
A federal report generated by Medicare for its providers that displays transaction information regarding Medicare claims processing and payments.

Generic Equivalents
Drug products are considered pharmaceutical equivalents if they contain the same active ingredient(s), are of the same dosage form, route of administration and are identical in strength or concentration. Pharmaceutically equivalent drug products are formulated to contain the same amount of active ingredient in the same dosage form and to meet the same or compendial or other applicable standards, but they may differ in characteristics such as shape, scoring configuration, release mechanisms, packaging, excipients (including colors, flavors, preservatives), expiration time, and, within certain limits, labeling. (FDA Approved Drug Products with Therapeutic Equivalence Evaluations, 23rd Edition, March 2003)

Generic Name
The official title of a drug or drug ingredients published in the latest edition of a nationally recognized pharmacopoeia or formulary.

Legend or Prescription Drugs
Any drugs required by any applicable federal or state law or regulation to be dispensed by prescription only or which are restricted to use by practitioners only.

Less Than Effective Drugs
See DESI.

Maximum Allowable
The maximum dollar amount a provider may be reimbursed for specific services, supplies, or equipment.

Maximum Allowable Cost (MAC) Program
The maximum amount paid for a specified dosage form and strength of a multiple source drug product.

Medicaid
The federal aid Title XIX program under which medical care is provided to:

- Categorically needy as defined in ARM
- Medically needy as defined in ARM

Medical Assistance
The federal aid Title XIX program under which medical care is provided to the categorically needy.

Medically Accepted Indication
Any use for a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, which appears in peer-reviewed medical literature or which is accepted by one or more of the following compendia:

- The American Hospital Formulary Service Drug Information;
- The American Medical Association Drug Evaluations;
- The United States Pharmacopoeia Drug Information; or
- DRUGDEX.

Medically Necessary
A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare
The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care and other health services and supplies not covered under Part A of Medicare.

Mental Health Services Plan (MHSP)
This program provides selected medically necessary mental health services to financially eligible individuals who are not eligible for Medicaid. The individuals must have been determined to have either a serious emotional disturbance or a severe disabling mental illness.

Multiple Source Drug
A drug marketed or sold by two or more manufacturers or labelers or a drug marketed or sold by the same manufacturer or labeler under two or more different proprietary names or both under a proprietary name.

NABP
National Association of Boards of Pharmacies.

National Drug Code (NDC)
An 11-digit number the manufacturer assigns to a pharmaceutical product and attaches to the product container at the time of packaging that identifies the product's manufacturer, dose form and strength, and package size.

Non-rebate Drugs
Drugs manufactured or distributed by manufacturers/labelers who have not signed a drug rebate agreement with the federal Department of Health and Human Services (DHHS) or the state Department of Public Health and Human Services (DPHHS).

Obsolete Drug
A drug that has been identified as obsolete by the manufacturer and is no longer available.

Obsolete NDC
A national drug code replaced or discontinued by the manufacturer or labeler.

Over-the-Counter (OTC) Drug
Drugs (non-legend) that do not require a prescription before they can be dispensed.

Pharmacist
A person duly licensed by the Montana State Board of Pharmacy to engage in the practice of pharmacy.

Pharmacy
Every site properly licensed by the Board of Pharmacy in which practice of pharmacy is conducted.

Point-of-Sale (POS)
A pharmacy claims processing system capable of adjudicating claims on-line.

Prescription
An order for drugs or devices issued by a practitioner duly authorized by law or rule in the State of Montana to prescribe drugs or devices in the course of his or her professional practice for a legitimate medical purpose.

Prospective Drug Use Review (Pro-DUR)
A process in which a request for a drug product for a particular patient is screened for potential drug therapy problems before the drug is dispensed.

Provider or Provider of Service
An institution, agency, or person:

- Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the department.

Provider Number
Number issued by the Department, for reimbursement.

Remittance and Status Report (RA)
A report produced by the claims processing system that provides detailed information concerning submitted claims and other financial transactions.

Retrospective Drug Use Review (Retro-DUR)
The process in which drug utilization by patients is reviewed on a periodic basis to identify patterns of fraud, abuse, gross overuse, or inappropriate or unnecessary care.

Single Source Drug
A drug produced or distributed under an original new drug application approved by the FDA, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application.

Terminated Drug Product
A product whose shelf life expiration date has been met, per manufacturer notification.

Therapeutic Equivalent
Drug products are considered to be therapeutic equivalents only if they are pharmaceutical equivalents and if they can be expected to have the same clinical effect and safety profile when administered to patients under the conditions specified in the labeling. (FDA Approved Drug Products with Therapeutic Equivalence Evaluations, 23rd Edition, March 2003)

Third Party
Any entity that is or may be liable to pay all or

Unit Dose Delivery
A drug delivery system in which each patient's medication is delivered in quantities sufficient only for the day's required dosage.

Usual and Customary
The fee that the provider most frequently charges the general public for a service or item.

Acronyms

This section contains a list of commonly used acronyms. Please refer to *Definitions* or specific chapters for more information.

ARM
Administrative Rules of Montana

AWP
Average wholesale price

CFR
Code of Federal Regulations

DAW
Dispense as written

DESI
Drug efficacy study index. Also referred to as "less than effective drugs".

DHHS
Federal Department of Health and Human Services

DPHHS
The state Department of Public Health and Human Services. Also referred to as *the Department*.

DUE CARE
Drug use education, concurrent and retrospective evaluation

DUR
Drug utilization review.

EAC
Estimated acquisition cost

EOMB
Explanation of Medicare benefits

FDA
Food and Drug Administration

MAC
Maximum allowable cost

MHSP
Mental Health Services Plan

NABP
National Association of Boards of Pharmacies.

NCPDP
National Council for Prescription Drug Programs

NDC
National drug code

OTC
Over-the-counter

PA
Prior authorization

POS
Point-of-sale

PRO-DUR
Prospective drug utilization review

RA
Remittance advice

Retro-DUR
Retrospective drug utilization review

TPL
Third party liability

VFC
Vaccines for children

Appendix A:
Forms

- ***Montana Medicaid Claim Inquiry Form***
- ***Montana Individual Adjustment Request Form***

Montana Medicaid/MHSP/CHIP Claim Inquiry Form

Provider Name _____
Contact Person _____
Address _____
Date _____
Phone Number _____
Fax Number _____

For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____
Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____
Provider number _____ Client number _____ Date of service _____ Total billed amount _____ Date submitted for processing _____	ACS Response: _____

Mail to: Provider Relations
P.O. Box 8000
Helena, MT 59604

Fax to: (406) 442-4402

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS

_____
Name

_____
Street or P.O. Box

_____
City State Zip

2. CLIENT NAME

_____

3. INTERNAL CONTROL NUMBER (ICN)

_____

4. PROVIDER NUMBER

_____

5. CLIENT ID NUMBER

_____

6. DATE OF PAYMENT _____

7. AMOUNT OF PAYMENT $ _____

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

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